SARINA CASTRO PH.D.
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CONSENT TO EXCHANGE CONFIDENTIAL INFORMATION

CLIENT NAME:_____

I, _____, give my permission for Dr. Sarina Castro to exchange information pertinent to my psychological care with the following person(s):

Name:_____
Title and Organization:_____
Relationship to Client:_____
Phone number and Email:_____

Name:_____
Title and Organization:_____
Relationship to Client:_____
Phone number and Email:_____

I understand that the information exchanged shall be limited to that which is necessary for treatment planning and coordination of care.
I understand that I may revoke this consent at any time and that my consent will automatically end at the termination of treatment.

_____ _____

Client Signature Date